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ABSTRACT

There is mounting evidence that the human immunodeficiency virus (HIV) that causes acquired immune deficiency syndrome (AIDS) is spreading rapidly among teenagers. To stop this spread of HIV infection, experts agree that states need to include HIV/AIDS prevention and education as an integral part of comprehensive health education programs for elementary and high school students. HIV is primarily spread among teenagers through unprotected sexual contact with an infected person or by sharing a needle with an infected person in the course of intravenous drug use. Education programs should strive to increase adolescent awareness of HIV/AIDS and the factors that determine their risk for disease; describe how the disease is transmitted and what can be done to prevent its spread; dispel misconceptions about how HIV is transmitted; encourage compassion toward people at high risk or people who have contracted HIV or HIV-related illnesses; and motivate adolescents to identify and change those behaviors that place them at risk for HIV infection. As of April 1990, 30 states and the District of Columbia require HIV/AIDS education in public schools. Programs are also needed to serve hard-to-reach youth and states need to include an evaluation component in their youth-related HIV education programs. In developing effective HIV/AIDS education programs, program development, implementation, evaluation, and refinement and targeting need to be stressed. (NB)

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ADOLESCENTS AND AIDS: STOPPING THE TIME BOMB

"There is no cure, there is no vaccine, there is only education."
"AIDS Quarterly," PBS, February 1, 1990

INTRODUCTION

There is mounting evidence that the human immunodeficiency virus (HIV), which causes AIDS (acquired immune deficiency syndrome), is spreading rapidly among teenagers.* By April 1990, the Centers for Disease Control (CDC), reported that 5,484 Americans from the ages of 20 to 24 years had been diagnosed with AIDS. Virtually all of these young adults are believed to have contracted HIV as teenagers. The CDC also reported 500 cases of AIDS among people 13 to 19 years of age. (28, p. 12) Experts agree that teens are at higher than average risk of contracting HIV because of their capricious and often risky behavior. Public health officials increasingly view teens as a conduit or bridge for transmission to the general population. (12, p. 1)

The only effective weapon in the fight against the spread of the deadly HIV infection is prevention. There is no cure for HIV disease and no vaccine. During the 1980s, more than 110,000 Americans were diagnosed with AIDS; a little over one-half have died. To stop the spread of HIV infection among teens, experts agree that states need to include HIV/AIDS prevention and education as an integral part of comprehensive health education programs for elementary and high school students. States also need to develop special educational outreach programs for hard-to-reach groups of teenagers engaging in behaviors that put them at high risk of becoming HIV infected.

AIDS AND ADOLESCENTS

HIV is primarily spread among teenagers through unprotected sexual contact with an infected person or by sharing a needle with an infected person in the course of intravenous (IV) drug use. These two means of HIV transmission account for 89 percent of all AIDS cases among people 13 to 24 years of age. (28, p.12) (See Figure 1.) While heterosexual contact accounts for only 12 percent of all AIDS cases diagnosed among 13- to 24-year-olds, there was a 36 percent increase from March 1989 through March 1990 in the number of cases attributed to this mode of transmission. (28, p. 12) Many teenagers engage in behaviors that put them at risk of contracting HIV.

- Seventy-eight percent of males and 63 percent of females have sexual intercourse in their teen years (15, p. 31); 57 percent of all teenagers have had sex before age 18. (19. p. 8)
- Among teens 15 years of age and older, at least one-third report having sex once a week or more. (15, p. 31)
- Only one-third of sexually active teenagers use contraceptives regularly and, of these, less than one-quarter use condoms. (1, p.1)
- Each year, 2.5 million teenagers contract a sexually transmitted disease (for example, syphilis or gonorrhea), or about one teenager in every six. (10, p. 1)

*"HIV" refers to the virus that damages the body's immune system and eventually cripples its ability to fight disease; "AIDS" refers to the syndrome caused by HIV infection, which is characterized by certain serious diseases or conditions such as the rare cancer Kaposi's sarcoma, pneumocystis carinii pneumonia or HIV dementia.

- Nationwide, 1 percent of high school seniors report having used heroin; 7 percent report having used cocaine. (19, p. 9) Both drugs may be injected.

There is one piece of good news: among those aged 17 to 19 living in metropolitan areas, condom use increased over the last decade from 21 percent to 58 percent. According to one study, however, "Condom use among those who are at the greatest risk of contracting AIDS [such as intravenous drug users, those engaging in sex with a prostitute, those with more than four sexual partners in one year] is significantly lower than the average." (25, p. 21) For example, only 21 percent of adolescents who had used, or whose sexual partner had used, intravenous drugs reported condom use during last intercourse.

Between 0.4 and 3.3 per 1,000 teenagers nationwide are estimated to be infected with HIV. Among teens in certain inner city areas and teens who routinely engage in high risk behaviors, the rates are much higher. Among women aged 15 to 24, AIDS is now the fourth most common cause of death in New York City. (10, p. 1)

Between March 1988 and March 1990, the number of teens with AIDS increased 100 percent, from 250 to 500. Because it can take as long as 10 years before an HIV-infected person has any symptoms of AIDS, most of those who become HIV infected as teens will not be diagnosed until they are well into their 20s. Unfortunately, once infected, HIV carriers can infect others, whether it be a sexual partner, a fetus in the case of an infected pregnant woman or someone with whom they share an unclean needle.

Certain teenagers are at higher risk of contracting HIV than others, namely those who routinely engage in unprotected sex with multiple partners, IV drug users who share unclean needles or syringes, and sex partners of these IV drug users. As a group, runaway and abandoned youths are far more likely than the average teenager to engage in these behaviors. There are an estimated 1.3 million to two million runaway and homeless youths in the United States each year. (12, p. 2) Of these, many engage in prostitution (between 125,000 and 200,000) and illegal drug use. (12, p. 2) Studies indicate that among runaway and homeless youths living on the streets, 7 percent to 15 percent or even more may be HIV infected. (9, p. 1)

EDUCATION PROGRAMS

Generally, the goals of HIV prevention and AIDS education programs for youth are the following:

- Increase teen awareness of HIV/AIDS and the factors that determine their risk for disease;
- Describe how the disease is transmitted and what can be done to prevent its spread;
- Dispel misconceptions about how HIV is transmitted;
- Encourage compassion toward people at high risk or people who have contracted HIV or HIV-related illnesses; and
- Motivate adolescents to identify and change those behaviors that place them at risk for HIV infection, through risk prevention, risk reduction or elimination, and maintenance of risk-reducing changes in behavior. (12, p. 3 and 13, p. 29)

Experts in health, drug abuse prevention, pregnancy prevention and sex education for youth cite several lessons based on their experience in trying to inform and affect the behavior of youths.

- Students exposed to educational approaches that use modeling, role playing and situation rehearsal "appear more likely to resist social and peer pressures--including

those that lead to early sexual involvement--than their counterparts who do not." (12, p. 5) For example, a six-month follow-up of adolescents in a course designed to help them avoid unplanned pregnancies by focusing on communication and problem solving skills through role playing found that the participants practiced more effective contraceptive methods and exhibited better communication skills than the control group. (29, p. 451)

- Multi-faceted, community-wide strategies that shower teens with reinforcing messages about family life, sexuality and teen pregnancy are more effective than one-shot programs such as those that rely on a single AIDS presentation in the schools. (12, p. 5) According to a report on AIDS education by the U.S. General Accounting Office, "The use of several personal media--community leaders, peers, teachers and health experts, for example--may contribute to an overall climate of issue importance, as each source reinforces the others." (13, p. 23) For example, a comprehensive, community-based adolescent education program designed to reduce pregnancies among teenagers in one South Carolina county reportedly lowered the number of pregnancies among unmarried adolescents by more than one-half. (15, p. 8)

- Studies of successful risk reduction programs have led researchers to recommend that education programs for youths emphasize the degree to which one is actually at risk of contracting HIV, guidelines for risk reduction and the degree to which following those guidelines will reduce one's risk. (14, p. 8)

- Abstract statistics on the incidence of a health problem may not motivate risk reduction as effectively as meeting a person who has it. (13, p. 54) According to one expert, when people with AIDS meet with students, "The message finally strikes home and . . . kids see the reality of the illness." (19, p. 30)

- Education programs should be based on the knowledge level of the target audiences; should be sensitive to the influence of peer pressures to engage in certain behaviors (such as sexual intercourse or drug use) and to disregard authority; and should focus on the concerns and misconceptions youths have about HIV/AIDS and other related health problems. (19, p. 13) A major misconception that programs should address is the belief that "if you look healthy, you don't have it."

- Teens appear to be more receptive to programs designed by their peers in which they play a major role. (7, p. 11) One study found that peers were not only effective educators but also more successful than their adult counterparts in reaching hard-to-reach clients. (23, p. 39)

- Materials should be designed for a particular audience. They should be sensitive to such characteristics as the age, developmental level, and cultural and ethnic background of the students who will use them. (31, p. 14)

School-based programs. As of April 1990, 30 states and the District of Columbia required HIV/AIDS education in public schools. Among the states that do not mandate HIV/AIDS education, Colorado, Maine, Massachusetts and Wisconsin, give high priority to local control over curricula. (22, p. 16) According to the National Association of State Boards of Education (NASBE), the following are components of mandatory state HIV/AIDS education programs (17):

- Most states add HIV/AIDS education to a broader state health education requirement.

- Sixteen states and the District of Columbia require HIV education to begin somewhere between kindergarten and grade five.

- With respect to the content of education programs, 20 states require that prevention be discussed; 18 require abstinence to be stressed; 10 describe specific elements of effective HIV/AIDS prevention and general reduction of risky behaviors; seven discuss avoidance of IV drug use and sharing hypodermic needles; three discuss condom use; and two discuss homosexuality.

- Sixteen states describe the state's role in providing materials; for example, a specific state agency may be required to develop and distribute learning materials or a model curriculum.

- Twenty-two states and the District of Columbia have developed student learning outcomes for HIV/AIDS education (for example, "Students must know the definitions of HIV and AIDS").

- Fifteen state programs address training and/or qualifications of HIV/AIDS education teachers.

- Nearly every state policy provides a role for the local community in developing and implementing HIV/AIDS education.

Only a few state programs include a requirement to assess the effectiveness of HIV/AIDS education programs. (17, p. 9) The Kentucky state education agency is developing indicators of program effectiveness (such as reduction of sexually transmitted diseases) to be reached by school year 1994-95. Minnesota has appropriated funds for an "independent evaluation" of its program. According to NASBE, state education agencies in Iowa, Maine, Michigan, North Carolina and Vermont are working with universities to evaluate their programs. (17, p. 26) Hawaii, which does not formally require HIV/AIDS education, nonetheless has appropriated funds for an AIDS interim student awareness program and requires that an evaluation be submitted to the Legislature.

Programs for hard-to-reach youths. The CDC is encouraging all states to develop programs tailored to the needs of certain youths for whom standard school HIV/AIDS education programs may not be adequate. This includes adolescents who are not in school, such as high school drop-outs; youths whose behavior may put them at high risk, such as users of IV and other drugs and homosexual and bisexual youths; hard-to-reach youths, such as runaway and homeless teens; teens for whom cultural or linguistic barriers make it likely that standard education programs will not work, such as those for whom English is a second language; and students with special needs, such as young people with developmental or emotional disabilities. (17, p. 27)

The Texas Omnibus AIDS Bill, enacted in May 1989, includes several directives designed to ensure that hard-to-reach and other targeted groups of young people are educated about HIV and AIDS. Among other things, the new legislation (which encourages but does not mandate HIV/AIDS education in the schools) directs the Texas Department of Health (TDH) to develop and promote targeted HIV education programs for people who may engage in behavior conducive to HIV transmission, people under 18 years of age, minority groups and people with disabilities. The act requires state-funded education and prevention programs to be accessible to people with physical disabilities. When making education grants, the TDH is directed to give special consideration to nonprofit community organizations whose purpose is serving people under 18 years of age. All substance abuse treatment facilities are required to educate employees and their clients in accordance with the model HIV/AIDS education program developed by TDH. The legislation also directs college and university student health centers to provide HIV education programs.

Among the states that require students to receive HIV/AIDS education, Minnesota is the only state with a policy that explicitly addresses the need to target prevention efforts for youths whose behaviors may place them at higher risk for infection. (17, p. 21) Minnesota requires each

district to have a program that at least includes ". . . a targeting of adolescents, especially those who may be at high risk of contracting AIDS, for prevention efforts."

Colorado has developed a model program for reaching out to youths in state residential facilities. The Colorado Department of Education's HIV Education Project targets emotionally and behaviorally disturbed adolescents and youths in juvenile detention centers. The department's program has several major components: first, the state's residential facilities for young people all receive information and materials similar to that received by school districts, but the material discusses high risk behaviors more explicitly; second, there are special two-day HIV training programs for residential staff which review legal and policy issues, explain how to conduct staff training and review the curriculum for adolescents; and third, each year the department surveys youths in residential facilities to assess their knowledge, attitudes and behavior about HIV. The department also surveys the facilities to determine what HIV education they are providing and who is involved. (27)

A 1989 HIV/AIDS education survey of adolescents in Colorado's 59 residential care facilities found that a majority of students (92 percent) recognize the need to be taught about HIV/AIDS in the school, but only 71 percent reported they had, in fact, been taught about it. While nearly all the students were aware that a person can get HIV from sharing needles to inject drugs, they had many misconceptions about other modes of infection. For example, 48 percent said that a person can contract the virus from being bitten by mosquitoes or other insects and 70 percent felt a person could become infected from donating blood. (30)

Washington state recently published a curriculum guide specifically designed for youths in correctional facilities and others at high risk. *Up Front About AIDS* was developed by the Office of the Superintendent of Public Instruction in recognition that HIV materials developed for students in public schools are not as effective with incarcerated youths since many have already been involved in sexual activity and drug abuse. (26, p. 1) The curriculum includes four lesson plans, a glossary, teacher's background and resource directory that cover such things as the stages and symptoms of HIV infection, how to prevent getting or transmitting HIV, and how to deal with friends and relatives with HIV infection or AIDS. The 44-page guide was developed with input from a 10-member advisory committee that included people from the Department of Health, a correctional center, a learning center, a detention center, the Department of Juvenile Rehabilitation, a group home and several local youth-serving agencies, as well as the Office of the Superintendent of Public Instruction.

Several community organizations are operating HIV prevention programs for selected youth populations which appear to be effective. The Children's Aid Society of New York City runs the Adolescent Pregnancy Prevention Program. Since it was established four years ago, the program has helped more than 200 Central Harlem youths stay HIV-free, pregnancy-free, enrolled in school and employed. The program focuses on raising students' self-esteem through family life and sex education, counseling, academic help, medical care and services, sports, performing arts and guaranteed college admission. (19, p. 9)

ASSESSING PROGRAM EFFECTIVENESS

HIV/AIDS education and prevention programs for teens are so new--the first school-based programs were established just a few years ago--that it is too early to tell whether or not they are actually discouraging teens from behaviors that put them at risk of contracting or transmitting HIV infection. The limited evidence available suggests that, as with other educational programs designed to change teens' behaviors, such as drug abuse and pregnancy prevention programs, HIV/AIDS education programs are having only a limited impact. A 1986 survey of 860 Massachusetts 16- to 19-year-olds found that of the 70 percent who reported being sexually active, 15 percent had changed their sexual behavior because they feared HIV infection, but only 20 percent of these had implemented effective changes. (15, p. 32)

Evidence exists that HIV/AIDS education programs are improving teens' knowledge about and understanding of the ways in which HIV is transmitted and how they can protect themselves from infection. In 1987, a nationwide survey of more than 11,000 eighth and 10th grade students found that 94 percent knew there is increased risk of HIV infection from having intercourse with an HIV-infected person; 91 percent knew that sharing drug needles increases the risk of HIV infection; 86 percent knew that condoms are an effective way to reduce the risk of HIV infection; and 91 percent agreed that adolescents should use condoms if they have sexual intercourse. (19, p. 9)

Programs for hard-to-reach teens also have demonstrated the ability to improve understanding of HIV prevention. A recently completed, independent evaluation of a New York City AIDS prevention and education program for adolescents in a truancy prevention and community after-school program found the program had a positive effect on the adolescents' knowledge and understanding of HIV and AIDS. Evaluators concluded that the AIDS Risk-Reduction Education and Skills Training (ARREST) program increased minority adolescents' knowledge about HIV transmission and prevention, enhanced the perception that they could effectively protect themselves from HIV infection, and improved their ability to discuss prevention and negotiate risk reduction. (18, p. 160)

Despite the success of school-based and community HIV/AIDS education programs in educating young people about the dangers of HIV infection and steps they should take to prevent getting the virus, studies suggest there are still some important information gaps that should be addressed. For example, in a survey of Montana seventh graders conducted last year, 32 percent of the girls and 17 percent of the boys did not know that using a condom reduces the chances of getting AIDS. (4, p. 10) Another study found that African American and Hispanic adolescents were less knowledgeable about HIV disease and more likely to have misconceptions about transmission than white students. (16, p. 36)

As noted earlier, few states include an evaluation component in their youth-related HIV education programs. To assist educators and others concerned about the spread of HIV, states should consider including a requirement for independent assessments of HIV/AIDS education programs. Such evaluations should assess not only changes in attitudes and knowledge but also behavioral changes, such as increased use of condoms, decrease in the average number of sexual partners or increase in the number of teenagers choosing abstinence.

CONCLUSION

States can play a significant role in educating teens about HIV prevention and AIDS. As the virus continues to spread, especially among teenagers, it is vital that students get the information, develop the skills, and understand and take the steps necessary to reduce or eliminate their risk of getting or transmitting HIV. States have a window of opportunity to control the further spread of HIV among adolescents at this critical stage of the epidemic. With the help of the CDC and other national, state and local organizations, states are working with local school districts to develop effective HIV/AIDS education programs. In this process, program development, implementation, evaluation of program effectiveness, and program refinement and targeting need to be stressed.

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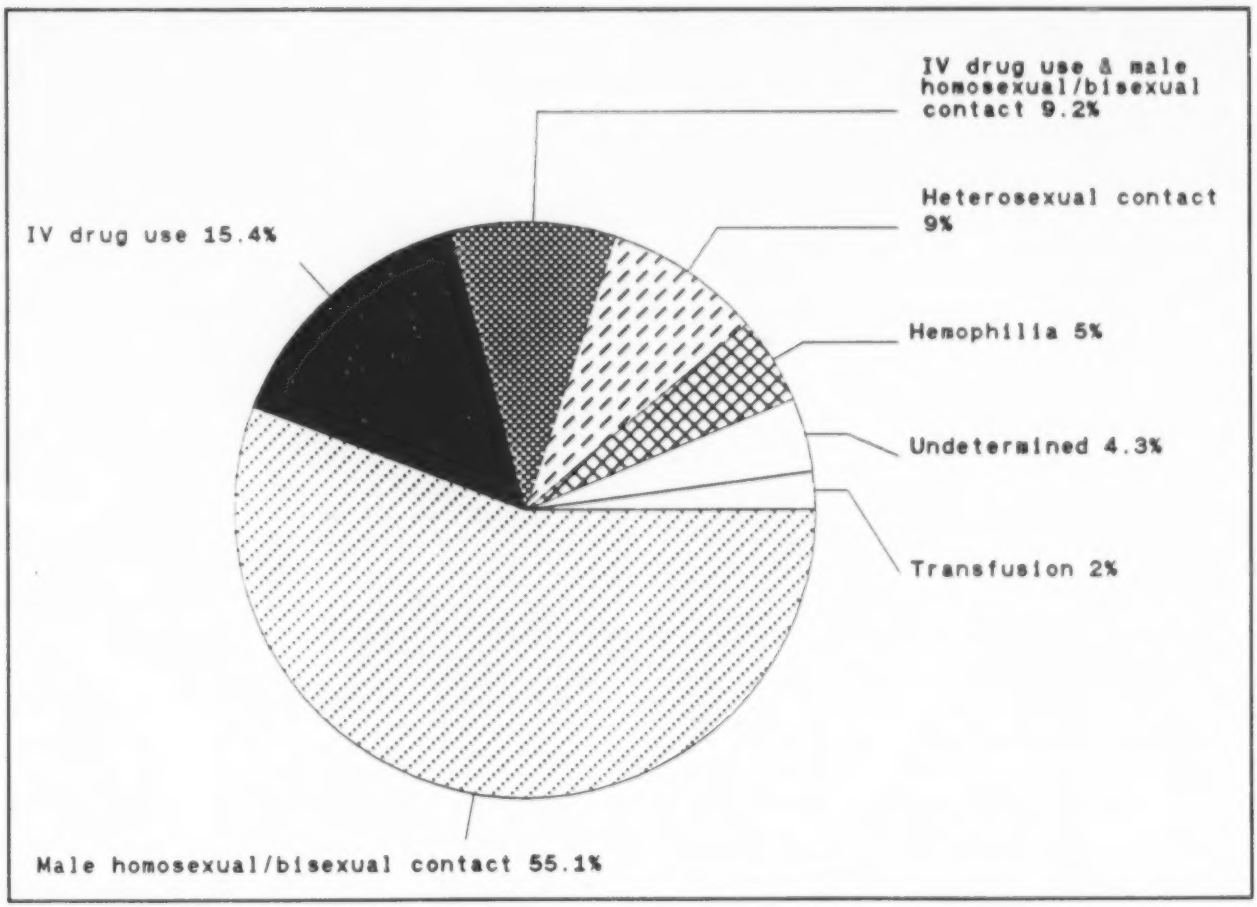
Figure 1.

Cases of AIDS Reported Among 13- to 24-Year-Olds (March 1990)

5,984 Total Cases

Distribution by Exposure Category



Source: Centers for Disease Control, *HIV/AIDS Surveillance Report*, April 1990: 1-18.

Table 1.

States That Require AIDS Education

	Date of Requirement	Designated Subject Area(s) in Which HIV/AIDS Education Is Required	Grade Levels[1]	Have Learning Outcomes Been Developed? Are They Required or Recommended?
Alabama	June 1987	CHE[2]	7-12	Required
Arkansas[3]	December 1989	(none)		
Connecticut	June 1987	(none)	K-12	Recommended
Delaware	September 1987	CHE: Communicable Diseases Area	3-12	Required
District of Columbia	October 1987	Communicable Diseases Requirement	4-12	Required
Florida	July 1988	1. CHE 2. Life Management Skills	9-12	Required
Georgia	May 1988	Sex Education	6-12	Required
Illinois	September 1987	Critical Health Problems and Comp. Health Education	6-12	
Indiana	July 1988	Communicable Diseases Requirement		
Iowa	July 1988	1. CHE 2. Human Growth and Development	1-12	Recommended
Kansas	May 1988	Human Sexuality	*	Recommended
Kentucky	March 1988	Parenting Skills and Family Life Education	K-12	Recommended
Maryland	October 1987	(none)	3-12	Recommended
Michigan	October 1987	(none)	3-12	Recommended
Minnesota	May 1988	(none)		
Nevada	April 1987	Human Reproduction		Recommended
New Jersey[3]	February 1990	CHE		
New Mexico	October 1987	CHE	**	
New York	September 1987	CHE	**	
North Carolina	July 1987	Communicable Diseases Requirement	7-12	Required
Oklahoma	April 1987	(none)	7-12	Required
Oregon	April 1988	CHE: Communicable Diseases Area	**	Required
Pennsylvania	July 1987	CHE: Communicable Diseases Area	**	
Rhode Island	February 1987	Family Life Education	7-12	Required
South Dakota	April 1988	(none)	K-12	Recommended
Tennessee	January 1988	(none)	K-12	Required
Utah	July 1988	CHE: Communicable Diseases Area	3-12	Required
Vermont	June 1988	CHE	*	Recommended
Virginia	March 1988	Family Life Education	5-12	Required
Washington	March 1988	Sexually Transmitted Diseases Requirement	5-12	Required
West Virginia	June 1988	CHE: Sexually Transmitted Diseases	7-12	Required

[1]Levels based either on state policy or state board of education specifications.
[2]CHE - comprehensive health education
*"elementary and secondary levels"
**"elementary, middle, and secondary levels"

[3]Source: Carolyn Burkhardt, National Association of State Boards of Education, Alexandria, Va., April 2, 1990: personal communication.

Source: Marie Schumacher, *HIV/AIDS Education Survey: Profiles of State Policy Actions* (Alexandria, Va.: National Association of State Boards of Education, 1989).

Table 2.
What Do The Policies Say?

Are the Following Topics Addressed in the Policy?	Teacher Training and Qualifications	Inservice Training for All School Staff	State Must Provide Information or Instructional Materials	Development of Local Advisory Boards	Monitoring and/or Evaluation of Programs	Instruction Must Emphasize Sexual Abstinence	Instruction Must Emphasize Abstinence From Drugs	Instruction Must Include Prevention Information
Alabama	x		x			x	x	
*Arkansas								
Connecticut	x		x					
Delaware					x	x		x
District of Columbia								x
Florida		x				x		x
Georgia			x			x		
Illinois			x			x		x
Indiana				x		x		
Iowa	x	x	x	x		x	x	x
Kansas	x			x	x			
Kentucky	x	x	x	x		x		
Maryland	x		x	x	x			x
Michigan		x			x			x
Minnesota	x							x
Nevada				x	x			
*New Jersey	x		x	x				
New Mexico					x	x		x
New York	x	x		x		x		x
North Carolina	x		x			x	x	x
Oklahoma			x			x	x	x
Oregon				x		x	x	x
Pennsylvania						x	x	x
Rhode Island		x				x		
South Dakota		x						
Tennessee	x		x		x			x
Utah	x		x		x	x		x
Vermont	x		x	x				x
Virginia	x	x	x	x		x		x
Washington		x	x			x	x	x
West Virginia	x		x		x			x

*Source: Carolyn Burkhardt, National Association of State Boards of Education, Alexandria, Va., April 2, 1990: personal communication.

Other Discussion of Content Areas of Instruction Within the Policy

Alabama. Program should avoid the depiction of specific homosexual activities unless deemed necessary by the state health department.

Georgia. State curriculum standards must address the handling of peer pressure and promote self-esteem.

Iowa. Local committees must address self-esteem, responsible decision making, personal responsibility and interpersonal relationships.

Kentucky. Course concepts and skills should include goal setting, self-discipline, decision making, communication skills and conflict resolution, developing a positive self-concept and handling peer pressure.

Minnesota. Program title is AIDS Prevention and Risk Reduction, suggesting an emphasis on behavior change.

Nevada. Program description includes education in sexual responsibility.

New Mexico. Content areas include dispelling myths, ways to reduce the risk of getting the AIDS virus, societal implications for the disease, and the ability of students to demonstrate refusal skills, overcome peer pressure and use decision-making skills.

North Carolina. In addition to lifelong mutual monogamy, the desirability and effectiveness of other prevention methods should be discussed; specifically, the use of condoms and the avoidance of contaminated needles and syringes. Sensitivity to the feelings and condition of people with AIDS and appropriate hygienic measures when handling blood should also be covered in education.

Oklahoma. Education must teach that engaging in homosexual activity, promiscuous sexual activity, intravenous drug use and intercourse, with or without condoms, with an HIV-infected person places one at risk of contracting HIV.

Oregon. Education must dispel myths, teach about hygienic procedures to reduce risk of exposure to HIV, and address responsible sexual behaviors to reduce or eliminate exposure to HIV.

Virginia. Education should foster positive self-concepts and provide mechanisms for coping with peer pressure and the stresses of modern living.

Washington. Education must teach about the dangers of sexual intercourse with or without condoms and that artificial means of birth control are not completely reliable means of protection.

West Virginia. The goal of the education is to provide students with the knowledge and skills necessary to avoid behaviors that will put them at risk.

Source: Marie Schumacher, *HIV/AIDS Education Survey: Profiles of State Policy Actions* (Alexandria, Va.: National Association of State Boards of Education, 1989).

National Conference of State Legislatures

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June 1990

The National Confererence of State Legislatures (NCSL) is pleased to send you a copy of the HIV/AIDS Project's most recent State Legislative Report (SLR).

The project would like your feedback to determine if this publication is useful in developing HIV and AIDS policies and programs in your state. Your evaluation is greatly appreciated and will assist us in producing future publications that explore HIV-related issues.

Please mail the completed form to: **Tracey Hooker, Health Services Program, NCSL, 1050 17th Street, Suite 2100, Denver, Colorado 80265**

Position (state senator, representative, legislative staff, state agency official, etc.) and committee membership or organization: _____

State: _____

Which SLR? ____ *Protecting Health Care Workers From HIV Infection*

____ *Adolescents and AIDS: Stopping The Time Bomb*

1. Has your knowledge increased as a result of the information presented in this publication?
   ____ yes ____ no
   In what respect? _____
   _____

2. Will the information from this publication be useful for policymaking or program development in your state? ____ yes ____ no
   How? _____
   _____

3. Will you share this publication with other individuals or groups? ____ yes ____ no
   If yes, who? (e.g., specific legislative committees, legislative staff, legislators, state agencies, private organizations, etc.)
   _____

4. Given a six-page limitation, what areas do you wish the publication had spent more or less time on? (e.g., specific state policies or programs, background information, etc.)
   _____

5. What other HIV and AIDS issues would you like NCSL to research and produce publications on?
   _____

6. Any further comments? _____
   _____

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HIV/AIDS* Information and Education Project for State Legislators

The National Conference of State Legislatures (NCSL) is in its second year of the HIV/AIDS Information and Education Project for State Legislators. The purpose of the project is to assist states in the development of sound, responsive and cost effective legislation that will prevent the spread of HIV, protect the rights of HIV-infected individuals, and create or monitor financing and service delivery options for people with HIV infection.

Legislators and legislative staff of the nation's 50 states, its commonwealths and territories are encouraged to request assistance from NCSL's HIV/AIDS Project. The following information and education services are available at no cost to legislators and staff:

- o information clearinghouse
- o publications
- o technical assistance
- o national meetings

In addition, NCSL exchanges policy information and participates in research projects and meetings with other public interest groups as a member of the Intergovernmental AIDS Resource Network. The Network consists of 10 national organizations representing officials at the state, county and municipal levels.

The project is funded through a cooperative agreement with the U.S. Centers for Disease Control and also receives funding as a member of the Intergovernmental AIDS Resource Network supported by the Robert Wood Johnson Foundation and the Ford Foundation.

For further information contact Tracey Hooker, policy specialist, at NCSL's Health Services Program (303/623-7800).

*The Difference Between HIV and AIDS

It is important for legislators to understand the distinction between the terms "HIV" and "AIDS" when formulating policies. There is an immense difference in being infected with HIV (human immunodeficiency virus) and being diagnosed as having AIDS (acquired immunodeficiency syndrome).

HIV is the term for the virus that damages the immune system and may eventually cripple the body's ability to fight disease. AIDS is the end stage of HIV infection. People who are infected with HIV are diagnosed as having AIDS if they develop certain serious diseases or conditions such as Kaposi's sarcoma (a rare skin cancer), pneumocystis pneumonia or HIV dementia.

Many more people are infected with HIV than have developed AIDS. An estimated one million individuals are believed to be infected. Many HIV-infected people will experience no symptoms of illness for up to 10 years or more. "HIV infection" more correctly defines the scope of the public health problem that legislators face today.

Below are some of the most regularly misunderstood phrases related to HIV:

Misleading	More Accurate
Infected with AIDS	HIV infection
AIDS virus	HIV (human immunodeficiency virus)
HIV virus	HIV
AIDS test	HIV antibody test
AIDS antibodies	HIV antibodies
Positive AIDS test	Positive test for HIV antibodies
AIDS transmission	HIV transmission
AIDS victim	PWA (person with AIDS) or PLWA (person living with AIDS)
High risk groups	High risk behaviors

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